STATE OF MONTANA
Department of Public Health and Human Services

PLAN OF CARE

Admit Date: _____ Update: _____	**DISCHARGE**	**READMITS**
Level I Date: _____		
Level II: No ☐ Yes ☐ MR ☐ MI ☐ Level II Date: _____		
Care Category: Nursing Facility (CC1/CC2) ☐ Hospital (CC3) ☐		

Recipient Name (Last, First, Middle)	**Address**				**Phone**
Medicaid Number (SSN)	**Date of Birth**	**Height**	**Weight**	**Sex**	**Marital Status**
Responsible Party (Name/Relationship)	**Address**				**Phone**
Significant Other (Name/Relationship)	**Address**				**Phone**
Primary Health Care Professional	**Address**				**Phone**
Hospital Preference	**Eligibility Category:** ☐ Elderly ☐ Disabled SDMI ☐ Under 21		**Residential Status:** ☐ Lives Alone ☐ Other_____ ☐ Lives with Family ☐ Live-in Attendant		
Medicare ☐Yes ☐ No **Medicare #**	**Other Insurance**				**Veteran** ☐Yes ☐No
Date of Referral to HCBS	**Referral Source**		**Phone Number**		**Interview Date**
Date of Referral to PAS	**Referral Source**		**Phone Number**		**Intake Date**
Allergies					

DATE	MEDICAL DIAGNOSES	ICD-9 CODE	DATE	MEDICAL DIAGNOSES	ICD-9 CODE

DATE	MEDICATIONS	DOSAGE	FREQUENCY	DATE	MEDICATIONS	DOSAGE	FREQUENCY

Comments:

Distribution: White-Provider; Yellow-Recipient; Pink-Suspense

Mental Status/Psychosocial Status

Diet: ☐ General ☐ Diabetic ☐ Low Salt ☐ Other (Specify) _____

Safety Measures/Functional Limitations (Specify)

Assistive Devices Used

Crisis Intervention Plan

FUNCTIONAL OVERVIEW

TASK	INDEPENDENT	NEEDS ASSISTANCE	DEPENDENT	TASK	INDEPENDENT	NEEDS ASSISTANCE	DEPENDENT
Bathing				Laundry			
Dressing				Shopping			
Exercise				Socialization			
Grooming				Telephone			
Toileting				Vision			
Continence				Hearing			
Transfer				Speech			
Mobility				Banking			
Assistive Devices				Money Mgmt			
Meal Preparation				Orientation			
Eating				Transportation			
Medications				Time Mgmt			
Escort				Other			
Household				Other			

OTHER TREATMENT/THERAPIES/SOCIAL SERVICES AND INFORMAL SUPPORT SYSTEMS

SERVICE	PROBLEM/NEED	PROVIDER	FREQUENCY

Recipient Name _____ Date _____

SERVICE DELIVERY PLAN			
SERVICE	SUPPORT REQUIRED	PROVIDER	FREQUENCY
Case Management	Coordination and monitoring	Spectrum Medical	ongoing
Adult Day Care			
Adult Residential (Assisted Living)			
Chemical Dependency Counseling Individual			
Chemical Dependency Counseling Group			
Illness Management Recovery			
Homemaker			
Homemaker Chores			
Habilitation Aide			
Habilitation-Residential			
Habilitation- Day Program			
Nutrition −Meals			
Nutrition ☐ Dietitian ☐Classes, Nutritionalist			
Occupational Therapy ☐Evaluation			
Occupational Therapy ☐Group			
Occupational Therapy ☐Individual			
Personal Emergency Response System-rental			
Personal Emergency Response System-install and test			
Personal Assistance Attendant			
Personal Assistance ☐per diem ☐Nurse Supervision			
Prevocational Services (If recipient ineligible for Voc Rehab)			
Private Duty Nursing ☐ LPN ☐ RN			
Psychosocial Consultation & extended State Plan			
Respite Care ☐Assisted Living ☐Nursing Home			
Respite Care-home			
RN Supervision			
Specialized Medical Equipment and Supplies			
Specially Trained Attendants			
Supported Employment (If recipient ineligible for Voc Rehab)			
Supported Living (bundled service)			
Transportation ☐ Miles ☐ Trip			
Wellness Recovery Action Plan (WRAP)			

PLAN ASSESSMENT SUMMARY

PHYSICAL SUMMARY:

Long-Term Goals:

Short-Term Objectives:

PSYCHOSOCIAL SUMMARY:

Long-Term Goals:

Short-Term Objectives:

DISCHARGE PLAN